BEFORE THE KANSAS WORKERS COMPENSATION APPEALS BOARD

LAURALEE A. LAFFERTY	)	
Claimant	)	
V.	)	
	)	Docket No. 1,063,440
OLATHE MEDICAL CENTER, INC.	)	
Self-Insured Respondent	)	

ORDER

STATEMENT OF THE CASE

Respondent appealed the November 20, 2014, preliminary hearing Order entered by Administrative Law Judge (ALJ) William G. Belden. Zachary A. Kolich of Shawnee Mission, Kansas, appeared for claimant. Mark J. Hoffmeister of Overland Park, Kansas, appeared for respondent.

The record on appeal is the same as that considered by the ALJ and consists of the transcript of the November 19, 2014, preliminary hearing and exhibits thereto; the transcript of the July 16, 2014, preliminary hearing; the September 25, 2014, independent medical evaluation report of Dr. Dan M. Gurba; and all pleadings contained in the administrative file.

ISSUES

Claimant alleged a right knee injury from an October 17, 2012, work accident. Claimant underwent surgery on January 8, 2013, to repair a small posterior horn lateral meniscus tear. Respondent acknowledges that injury is compensable. In July 2014, at her own expense, claimant underwent a second right knee surgery to repair a complex medial meniscus tear. Claimant alleges the prevailing factor causing her right medial meniscus tear and need for additional medical treatment was her October 17, 2012, accident.

Respondent asserts claimant failed to prove her October 17, 2012, accident was the prevailing factor causing her right medial meniscus tear and need for additional medical treatment. Respondent asserts claimant's right medial meniscus tear was caused by an intervening February 2013 incident or was degenerative in nature.

The ALJ granted claimant's requests for medical treatment, unauthorized medical benefits of $500 and temporary total disability benefits, but reserved the issues of payment of and reimbursement for medical expenses. The ALJ found claimant's work accident was

the prevailing factor causing her right complex medial meniscus tear. Respondent appeals.

The issues are:

1. Was claimant's accident the prevailing factor causing her right medial meniscus tear and need for medical treatment?

2. Is claimant entitled to medical treatment as ordered by the ALJ?

FINDINGS OF FACT

After reviewing the record compiled to date and considering the parties' arguments, the undersigned Board Member finds:

The ALJ's Order sets out findings of fact from page 1 through the first full paragraph on page 4. Those facts are detailed and accurate and this Board Member adopts the ALJ's findings of fact as his own. This Board Member, however, notes certain facts that bear emphasis.

On November 13, 2012, claimant underwent a right knee MRI. The MRI report indicated claimant had a vertically oriented tear involving the posterior horn of the medial meniscus and a small area of bone marrow edema along the lateral aspect of the medial tibial plateau. The MRI report also indicated the anterior horn of the medial as well as the lateral menisci were intact.

Dr. Prem Parmar surgically repaired claimant's torn right knee lateral meniscus on January 8, 2013. The doctor found during surgery that the lateral meniscus was torn, but the medial meniscus did not have a tear. Dr. Parmar's medical treatment records were not placed into evidence.

Claimant testified that in February 2013, she was standing on a riser at her child's school when she twisted slightly to allow another person to pass. Claimant alleges her right knee gave out and she fell down and landed on her foot, injuring it. She avowed she did not injure her right knee during the incident.

Claimant testified that following her January 2013 right lateral meniscus repair, she had physical therapy and follow-up visits with Dr. Parmar. Claimant testified she was released to full duty with no restrictions, but her right knee was still very sore and swollen. She testified she had multiple instances of her right knee locking up and feeling as though it would give way as she was walking. Claimant indicated she told Dr. Parmar of these issues and requested additional medical treatment, including an MRI. However, Dr. Parmar declined to order an MRI.

According to claimant, she demanded additional treatment from respondent. Respondent sent her to Dr. Matthew M. Thompson, who saw claimant on April 4, 2014. In his report, Dr. Thompson indicated claimant underwent an MRI after her work injury showing a medial meniscus tear. When she subsequently underwent surgery, there was no medial meniscus tear, but rather a small lateral meniscus tear at the posterior root and grade II to III chondromalacia of the patella. The doctor stated:

> She notes that she had mild persistent knee pain after the injury and surgery. She then notes having a twisting injury, not at work, when her knee gave out. She also injured her foot at this time. She states since this time, her knee pain has been worse. Pain is anteriorly and medially over knee.[1]

Dr. Thompson recommended claimant undergo another right knee MRI. He also indicated claimant had a new injury to her right knee not sustained at work.

Claimant underwent a second MRI on May 23, 2014. The MRI report of Dr. Wyatt L. Hadley indicated the MRI showed a large complex tear of the posterior horn of the medial meniscus and an area of near full-thickness cartilage fissuring of the patellar apex. It was also noted there was grade II chondromalacia involving the posterior weight-bearing surface of the medial femoral condyle.

Dr. Edward J. Prostic examined claimant at her attorney's request on May 28, 2014. Dr. Prostic opined claimant's October 17, 2012, accident was the prevailing factor for her injury, medical condition and need for medical treatment. Dr. Prostic stated:

> On or about October 17, 2012, Lauralee A. Lafferty sustained injury to her right knee. Though she had MRI-evidence of torn posterior horn of the medial meniscus by MRI, Dr. Parmer *[sic]* was unable to find that tear and debrided a small tear of the posterior horn of the lateral meniscus, loose cartilaginous flaps from the patella, and excised a large medial patellar plica. During rehabilitation from that injury and surgery, she had a giving way episode of her knee with aggravation of the knee and foot fracture. She has had subsequent MRI of the knee that showed complex tearing of the medial meniscus. The worsening of MRI-appearance of the medial meniscus can be the natural consequence of a tear noted prior to surgery and can be aggravated by any traumatic incident. The giving way of the knee subsequent to the first surgery could have accelerated the worsening of the meniscus and would be the natural consequence of the injury sustained October 17, 2012. She needs to have repeat arthroscopic debridement of her knee with removal of loose portions of the medial meniscus. . . .[2]

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[1] P.H. Trans. (Nov. 19, 2014), Resp. Ex. B at 1.

[2] *Id.*, Cl. Ex. 1 at 3.

Claimant sought treatment from her family physician, Dr. Wolf, who referred claimant to Dr. Thomas J. Rasmussen, an orthopedic physician. In his notes from their initial appointment on June 23, 2014, Dr. Rasmussen noted:

> She underwent a right knee arthroscopy. Her MRI had showed evidence of a medial meniscus tear although at the time of surgery she did not appear to have this. She did have a small lateral meniscus tear and patellar changes which were debrided. She states that three weeks after that she pivoted and felt as though her leg gave out. She fell. She was subsequently noted to have foot fractures and did notice medial knee pain at that point. She was seen by her work physicians who did not feel these were related and she has subsequently resolved her work comp issues. She now complains of continued medial knee pain. She has recently undergone an MRI which shows a complex tear of the medial meniscus.[3]

On July 29, 2014, Dr. Rasmussen repaired claimant's right medial meniscus and performed a patellar chondroplasty. The doctor stated: "There was noted to be both very small undersurface tear as well as superior surface tear which then fell into an area of myxoid degeneration which was grossly unstable. This was felt to be responsible for her symptoms."[4]

By Order of the ALJ, claimant was evaluated by Dr. Dan M. Gurba on September 25, 2014. The doctor's report makes no mention of the February 2013 incident involving claimant's right knee at her child's school. Dr. Gurba noted that when Dr. Parmar operated on claimant's right knee in 2013, he repaired a small lateral meniscus tear and observed a normal appearing medial meniscus. Dr. Gurba noted that after her surgery by Dr. Parmar, the right knee pain persisted and claimant developed intermittent giving way of her right knee. Dr. Gurba opined:

> It is my opinion, within a reasonable degree of medical certainty, that the work injury sustained in October of 2012 was the prevailing factor for the persistent pain and need for subsequent treatment. It is also my opinion, that the meniscal tear and mucoid degeneration were present at her first arthroscopy but was not identified, most likely because of the "intrasubstance["] nature of the tear. This was identified at her second arthroscopy and a meniscal debridement was performed. . . .[5]

In letters dated August 5 and November 18, 2014, Dr. Parmar responded to correspondence he received from respondent's counsel. In the August 5, 2014, letter, Dr. Parmar stated:

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[3] *Id.*, Cl. Ex. 3.

[4] *Id.*

[5] Gurba IME Report at 3.

> At the time of surgery, examination under anesthetic revealed no evidence of any instability of her right knee. At the time of right knee arthroscopy, all three compartments of her knee were visualized and she was found not to have a medial meniscal tear as suggested by the MRI. It is not uncommon that an MRI can overcall or undercall things, as you know. She did, however, have a small lateral meniscal tear and underwent a partial lateral menisectomy at the time. She rehabilitated and slowly improved. She was last seen in April of 2013. At the last visit, there was no instability of her knee noted.
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> . . .
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> With respect to question #2, with reference to the preoperative MRI which revealed a medial meniscal tear and the subsequent MRI that was performed after her surgery which revealed a meniscal tear, I can say with absolute 100% certainty that there was no medial meniscal tear in the patient's right knee at the time of operation that I performed in January of 2013. . . .[6]

Dr. Parmar wrote his November 18, 2014, letter after reviewing Dr. Gurba's report. Dr. Parmar was adamant that claimant's medial meniscus tear was not work related. The doctor stated:

> Dr. Gurba felt that since the MRI prior to the first surgery revealed a complex medial meniscal tear and that the MRI before her second surgery revealed the same and at the time of the second surgery, she was found to have a medial meniscal tear that she must have had this intrasubstance tear at the time of the first surgery. First of all, I feel that it is important to note that an intrasubstance tear is 100% indicative of a degenerative tear. A degenerative meniscal tear starts out as mucoid degeneration within the substance of the meniscus that one can visibly not see with the naked eye when doing surgery but as the degenerative process continues, it works its way out and then becomes apparent. It is almost akin to a person having a jelly doughnut and not knowing what filling is within it and then they take a bite and then they know what is inside. Obviously in orthopedic surgery, we do not do this as we would be removing normal meniscus and it would not be in the patient's best interest. In Dr. Gurba's IME, he states that during the first surgery that I performed that I inspected the medial meniscus. That is quite accurate, but what he fails to mention is that I also probed it which means I physically take a probe into the knee joint, inspect the meniscus above and below and palpate it and pull on it to ensure that there is no hidden tear. If one looks at my operative report, I did this near the beginning of the case and then at the completion of the case once I had done everything else that I needed to do. Having done well over 4,000 of these, I know the patient did not have a meniscal tear that one would treat with a partial menisectomy. I say that with absolute and unequivocal 100% certainty. The fact that this patient had an intrasubstance tear which again is the beginning of a degenerative tear and had subsequent surgery a year and a half later would confirm

[6] P.H. Trans. (Nov. 19, 2014), Resp. Ex. A.

> the fact that her degenerative tear progressed to the point where when she had her second surgery, the appropriate surgery was done. It also tells us that because of this degenerative nature of the tear, it is not a work-related injury and therefore not compensable to be paid by Worker's Compensation Insurance. Therefore, the prevailing factor for her meniscal tear of the medial meniscus is not from her work injury of autumn of 2012. . . .
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> . . .
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> At the time of surgery, if a degenerative tear has progressed to the point where it is visible at the time of surgery, in other words there is a communication with the joint and one can actually see into the tear then one performs a partial menisectomy which was done in this patient's case at her second surgery when her treating orthopedic surgeon found that the degenerative tear had progressed to the point where she needed a meniscectomy, and if one looks at her intraoperative pictures from her July 2014 surgery which was her second surgery, if one looks at pictures #14 and #15 of her intraoperative arthroscopic pictures, one sees the classic picture of horizontal fish mouth appearance of the tear at the end of her surgery. This again is 100% conclusive evidence that this patient has had a degenerative tear. This is not the tear pattern of a traumatic tear. . . .[7]

As noted above, the ALJ found claimant's accident was the prevailing factor causing her injury and need for medical treatment. The ALJ stated:

> The Court first addresses the issue of the compensability of Claimant's complex medial meniscus tear, which is the subject of the request for medical treatment. To be compensable, an accident must be identifiable by time and place of occurrence, produce at the time symptoms of an injury and occur during a single work shift. K.S.A. 2011 Supp. 44-508(d). The accident must be the prevailing factor in causing the injury, and "prevailing factor" is defined as the primary factor compared to any other factor, based on consideration of all relevant evidence. *See* K.S.A. 2011 Supp. 44-508(d), (g). An accidental injury is not compensable if work is a triggering factor or if the injury solely aggravates, accelerates or exacerbates a preexisting condition or renders a preexisting condition symptomatic. K.S.A. 2011 Supp. 44-508(f)(2). Furthermore, the accidental injury arises out of employment only if there is a causal connection between work and the accident, and if the accident is the prevailing factor causing the injury, medical condition and resulting disability or impairment. K.S.A. 2011 Supp. 44-508(f)(2)(B). An injury that occurs as a result of the natural aging process is not considered to arise out of and in the course of employment. K.S.A. 2011 Supp. 44-508(f)(3)(A). In this case, it is undisputed Claimant was involved in an incident on October 17, 2012. The issue is whether the incident of October 17, 2012 was the prevailing factor causing the alleged medical condition: The complex medial meniscus tear.

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[7] *Id.*

> In this case, Dr. Prostic opined the work-related accident of October 17, 2012 was the prevailing factor causing the complex medial meniscus tear, without further comment. Dr. Prostic also opined Claimant sustained a foot injury, but this is premised on a mechanism of injury unsupported by Claimant's testimony. On the other hand, Dr. Parmar opined Claimant's medial meniscus pathology was unrelated to the accident of October 17, 2012 because he did not visualize a tear and probing did not evidence an occult pathology. Dr. Parmar did not mention probing the meniscus in his August 5, 2014 report and the Court does not have the operative report of Dr. Parmar to verify this statement. Dr. Rasmussen did not address the etiology of Claimant's condition. Dr. Gurba, the Court-ordered neutral physician, stated the complex medial meniscus tear was caused by the October 17, 2012 accident and was present, but not visualized, at the first surgery because it was intrasubstance in nature. This is a plausible explanation. Based on the medical evidence presented, the Court finds the opinions of Dr. Gurba the most credible of the medical opinions on the cause of Claimant's condition, and finds the work-related accident of October 17, 2012 was the prevailing factor, compared to any other factor, causing the complex tear of the medial meniscus repaired by Dr. Rasmussen. Although Claimant may have experienced joint pain prior to October 17, 2012, no evidence was presented suggesting the complex medial meniscus tear existed before the accident. The Court concludes Claimant met her burden of proving the compensability of the complex medial meniscus tear.[8]

PRINCIPLES OF LAW AND ANALYSIS

The Workers Compensation Act places the burden of proof upon the claimant to establish the right to an award of compensation and to prove the conditions on which that right depends.[9] "'Burden of proof' means the burden of a party to persuade the trier of facts by a preponderance of the credible evidence that such party's position on an issue is more probably true than not true on the basis of the whole record unless a higher burden of proof is specifically required by this act."[10]

K.S.A. 2012 Supp. 44-508(g) states:

> "Prevailing" as it relates to the term "factor" means the primary factor, in relation to any other factor. In determining what constitutes the "prevailing factor" in a given case, the administrative law judge shall consider all relevant evidence submitted by the parties.

This is an extremely close case with facts supporting the position of both parties. Supporting claimant's position are the following factors:

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[8] ALJ Order at 4-5.

[9] K.S.A. 2012 Supp. 44-501b(c).

[10] K.S.A. 2012 Supp. 44-508(h).

- Claimant's November 13, 2012, MRI revealed a vertically oriented tear involving the posterior horn of the medial meniscus of her right knee.

- Claimant testified that following her first arthroscopic right knee surgery, she continued having pain, swelling and multiple instances of the right knee locking up and feeling as though it would give way. Claimant indicated she told Dr. Parmar of those issues and requested another MRI, which was refused.

- Dr. Prostic, claimant's expert, opined claimant's accident was the prevailing factor causing her right knee injury and need for medical treatment.

- Dr. Gurba, appointed by the ALJ to evaluate claimant, opined claimant's medial meniscal tear was present at her first arthroscopy, but was not identified because of the intrasubstance nature of the tear. The doctor opined claimant's October 2012 work injury was the prevailing factor for her persistent pain and need for medical treatment.

In favor of respondent are the following factors:

- When Dr. Parmar operated on claimant's knee, he discovered a lateral meniscus tear that he repaired, but no medial meniscus tear. The doctor indicated that he observed, probed, palpated and pulled claimant's medial meniscus at the beginning and end of the arthroscopic surgery, but found no evidence of a medial meniscus tear.

- Dr. Parmar noted it is not uncommon that MRIs "overcall or undercall things."

- In February 2013, claimant twisted, her right knee gave way and she fell while at a school activity, injuring her right foot.

- Dr. Thompson's notes indicated claimant reported her right knee went out during the aforementioned incident and since then her pain worsened.

- Dr. Parmar provided a detailed explanation as to why claimant's medial meniscus tear repaired by Dr. Rasmussen was caused by a degenerative condition, not a traumatic incident.

- Dr. Gurba's report does not indicate he was aware of the February 2013 incident involving claimant's right knee.

Claimant has the burden of proving more probably than not that her October 2012 accident was the prevailing factor causing her medial meniscus tear and need for medical treatment. After much thought and consideration, this Board Member reverses the

preliminary hearing Order and finds that at this juncture in the proceedings, claimant failed to meet her burden of proof.

Dr. Gurba is, in essence, second guessing Dr. Parmar. Dr. Gurba's prevailing factor opinion is based upon the November 2012 MRI that showed a medial meniscus tear, but no lateral meniscus tear. When he operated, Dr. Parmar only discovered a lateral meniscus tear. Apparently, Dr. Gurba places more faith in the November 2012 MRI than Dr. Parmar's examination of claimant's medial meniscus. This Board Member finds the opinions of Dr. Parmar more credible because he actually probed, palpated and pulled claimant's medial meniscus and determined it had no tear. This Board Member concurs with Dr. Parmar that MRIs are not always 100% accurate. Moreover, Dr. Gurba's report does not indicate he was aware of the February 2013 incident involving claimant's right knee.

By statute the above preliminary hearing findings are neither final nor binding as they may be modified upon a full hearing of the claim.[11] Moreover, this review of a preliminary hearing Order has been determined by only one Board Member, as permitted by K.S.A. 2013 Supp. 44-551(l)(2)(A), as opposed to being determined by the entire Board when the appeal is from a final order.[12]

WHEREFORE, the undersigned Board Member reverses the November 20, 2014, preliminary hearing Order entered by ALJ Belden.

IT IS SO ORDERED.

Dated this ____ day of February, 2015.

HONORABLE THOMAS D. ARNHOLD
BOARD MEMBER

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William G. Belden, Administrative Law Judge

[11] K.S.A. 2013 Supp. 44-534a.

[12] K.S.A. 2013 Supp. 44-555c(j).